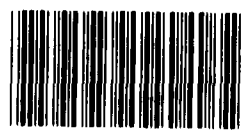
UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-196673

JUNE 15, 1983

The Honorable Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
Committee on Energy and Commerce
House of Representatives



The Honorable Claude Pepper, Chairman
Subcommittee on Health and Long-Term Care
Select Committee on Aging
House of Representatives

Subject: Federal Funding of Long-Term Care for the Elderly (GAO/HRD-83-60)

Your November 15, 1982, letter asked us to (1) compile data on the amount of Federal funds spent on long-term care for the elderly under various programs and (2) determine the amount being spent for backup hospital days of care; that is, when a patient spends a day in an acute care hospital when a lower level of care was needed, but a bed at that level was not available. Since your request, a Government-funded study concerning the amount of expenditures for long-term care was completed. Your offices agreed that the information in that report satisfied the questions about expenditures for long-term care in your letter and that we would address your concerns in light of the study. We also agreed to discuss the problem of obtaining accurate national data on backup days of care.

In summary, the Urban Institute found that at least $13.4 billion in Federal and State funds was being spent under various Government programs to provide long-term care to the elderly and disabled. The problem of backup days of care was first reported by us in 1978. The data on backup days of care are old, of questionable consistency, and not available on a national basis. Although the Social Security Act was amended in 1980 to reduce the payment level for these backup days to the payment level of the services actually rendered, this section of the law has not been implemented by the Health Care Financing Administration (HCFA).

(106244)

FEDERAL LONG-TERM CARE PROGRAMS FOR THE ELDERLY

On September 30, 1980, the Department of Health and Human Services (HHS) entered into a contract with the Urban Institute to analyze existing data bases on long-term care in order to develop data on national expenditures for such care and to address a number of other policy questions.

A January 1983 Urban Institute working paper entitled, "Public Programs Financing Long Term Care" reported that at least $13.4 billion in funds from the Medicaid, Medicare, Older Americans Act, Supplemental Security Income, title XX of the Social Security Act, and Veterans Administration programs were spent for long-term care. The Urban Institute defined long-term care services as a broad range of services including nursing home care, intermediate care facilities (ICFs) for the mentally retarded, residential care and treatment services, foster care, in-home services, community-based services, home health, and meals. The table on the following page shows, as reported by the Urban Institute, the total Federal and State expenditures in fiscal year 1980 and the percentage distribution of funds by program.

BACKUP HOSPITAL DAYS

You requested that we determine the amount being paid to acute care hospitals for those patients for whom long-term care is appropriate but unavailable. We described these as backup days of care which are usually paid for at the acute care hospital rate.

The concern about backup days is a long standing one. This problem was first discussed by us in two October 23, 1978, reports.[1] In trying to determine the extent of backup days in conjunction with the Ohio Hospital Association, Ohio hospitals were surveyed in August 1977. The hospitals that responded (123 of 218 or 56 percent) reported that on the day of the survey 223 Medicaid and 944 Medicare patients were awaiting placement in a skilled nursing facility (SNF). The estimated cost of maintaining these patients in hospitals was about $38,000 for Medicaid

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[1]"Improved Administration Could Reduce the Costs of Ohio's Medicaid Program" (HRD-78-98) and "Ohio's Medicaid Program: Problems Identified Can Have National Importance" (HRD-78-98A), both issued on October 23, 1978.

Public Expenditures on Long-Term Care Services by Program for Fisca

Service category	Total reported expenditures in the United States	Percentage distribution by p			
		Medicaid (note a)	Medicare	Older Americans Act (note a)	Supplementa Security Income (note a)
	(in millions)				
Total	c/$13,454	76.3	6.9	5.2	2.7
Nursing home	8,586	92.3	d/3.6	(e)	-
Intermediate care facility for the the mentally retarded	1,977	100.0	-	-	-
Nonmedical facility	506	-	-	-	73.1
Foster care	13	-	-	-	-
Day care	21	3.3	-	-	-
Home health	775	18.2	g/80.8	-	-
In-home	668	32.6	-	6.3	-
Community	462	-	-	i/45.2	-
Meals	447	-	-	98.0	-

a/Includes both Federal and State funds.
b/Expenditures for fiscal year 1979.
c/Figures do not add to total due to rounding.
d/Expenditures for calendar year 1979.
e/Nursing home ombudsman services - $3,789,000. Less than .05 percent.
f/Residential care and treatment services.
g/Expenditures for calendar year 1980.
h/Includes services reported under the following categories: homemaker, chor
i/Includes referral, transportation, community (other than legal), and in-fac
j/Includes services reported under the following categories: special service
education and training, transportation, health related, special services fo
socialization, transitional care management, protective services for adults
improvement, counseling, recreational, diagnosis and evaluation, and emerge

and $161,000 for Medicare patients per day ($170 per patient) or $13.8 million and $58.6 million per year, respectively.[2]

We found that even though Federal law requires State Medicaid programs to provide the lower cost alternative of SNFs for patients who do not require full hospital care, Ohio was not able to provide this lower cost care. Thus, many patients who could be adequately cared for in SNFs had to be kept in hospitals where costs are much higher. All affected parties--hospitals, SNFs, and the Ohio Medicaid program--agreed that many Medicaid patients who should be transferred to SNFs remain in hospitals primarily because SNFs are unwilling to accept them. They all agreed this problem occurred because the State's maximum rate, $26 per patient day at that time, was not enough to cover the cost of skilled care. Also, Medicare patients were affected by the nursing homes' concern that the patients would become eligible for Medicaid after exhausting their resources and thus the nursing homes would only receive the low rate.

In an October 1979 report[3] we stated that for quarters beginning after December 1978, all Professional Standards Review Organizations (PSROs) were instructed to report all days for which they approved hospital stays because a bed in a SNF or an ICF was not available. As of October 5, 1979, 139 PSROs had submitted data to HHS for the January to March 1979 period. Over 15.9 million Medicare and Medicaid inpatient hospital days had been approved for payment by the reporting PSROs. Of this total, 251,849 were approved because the patient was awaiting placement at a lower level of care.

A November 1979[4] GAO report discussed the results of a number of studies on backup days. One study indicated that in New York State on February 28, 1979, a large number of backup days occurred which on an annualized basis represented about $216.9 million in payments for backup hospital days. The study reported that 2,514 Medicare and 1,447 Medicaid patients had been

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[2]HCFA estimates that by placing hospitalized patients in a nursing home, 40 percent of the hospital per diem is saved. The remaining 60 percent represents fixed costs which are incurred by hospitals whether or not a bed is occupied.

[3]"Potential Effects of a Proposed Amendment to Medicaid's Nursing Home Reimbursement Requirements" (HRD-80-1, Oct. 15, 1979).

[4]"Entering a Nursing Home Costly Implications for Medicaid and the Elderly" (PAD-80-12, Nov. 26, 1979).

awaiting placement for a total of 143,852 days. The estimated cost of caring for these patients in hospitals was $594,150 per day ($200 per hospital day less $50 for SNF day times 3,961 patients).

Current data on backup days not available

A November 1981 report by the Urban Institute[5] indicated that estimates of backup days range from 250,000 to 2.3 million for a 3-month period. The 250,000-day estimate was based on PSRO data which had been submitted to HCFA. This is the same data discussed on the previous page and was included in our October 15, 1979, report. The Urban Institute pointed out that these data are not precise enough to determine the number of backup days. The study only contained data from 82 percent of the PSROs and had complete data for 18 States. In addition, the data were understated because some PSROs were only reviewing selected patients and reporting on those reviews.

According to HCFA officials much of the PSRO-reported data on backup days was incomplete. According to these officials, the data were never verified and they believe that the data were not reported on a consistent basis.

As of February 1983, 5,012 of the 6,747 Medicare-certified hospitals were covered by PSRO review. The remaining 1,735 hospitals have their claims reviewed by facility utilization review committees and Medicare's claims processing agents. In June 1981, when PSRO funding was reduced, HCFA deleted the requirement that PSROs report on backup days that had been approved for payment. Medicare claims processing officials told us that generally these days are paid for at an acute care rate and that they do not keep track of backup days. Because a comprehensive data identification and collection process does not exist, we are unable to collect national data.

LEGISLATIVE ACTION

Section 902 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499, Dec. 5, 1980) amended the Social Security Act to require that hospitals be paid by Medicare at the average Medicaid SNF rate in the State for backup days of care when:

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[5]"Medicare and Medicaid Patients' Access to Skilled Nursing Facilities," Working Paper 1438-02, November 1981.

--posthospital care is needed but unavailable,

--hospital services are not medically necessary, and

--the patient is entitled to have payment made for this posthospital care.

Medicaid would pay for backup hospital days under the same conditions based on the average Medicaid SNF or ICF rate depending on which level of care the patient required. This section was to become effective on the date HHS issued final regulations. The regulations were to be issued no later than June 1, 1981. As of April 1983, HCFA had not issued the regulations for Medicare. HCFA officials told us that the regulations were not issued because they are trying to determine how such a regulation would impact on the existing hospital reimbursement limits and the recently enacted Medicare prospective payment systems for hospitals (see section 601 of Public Law 98-21). As pointed out in our October 23, 1978, report, some money could be saved by paying for backup days of hospital care at a SNF rate and we still believe this to be the condition today.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our review were (1) to provide data on amounts spent on long-term care for the elderly under various Federal programs and (2) to review data on the amount being spent for backup days of care. To accomplish these objectives we reviewed and discussed with appropriate Urban Institute officials various Institute reports dealing with long-term care. We reviewed the provisions of Public Law 96-499 and prior GAO reports dealing with inappropriate days of care. We interviewed HCFA and various Medicare claims processing officials concerning backup days of care.

Our work was performed at HHS and the Urban Institute in Washington, D.C., and at HCFA headquarters in Baltimore, Maryland.

As requested by your offices, we did not obtain comments from the various agencies discussed in this report.

Except as noted above, our work was done in accordance with generally accepted government audit standards.

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Unless you publicly announce its contents earlier, no further distribution of this report will be made for 30 days. At that time, we will send copies to interested parties and make copies available to others upon request.

Richard L. Fogel
Director